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Integrating Sexual Health into Your Practice

Announcer:
This is SexMed on ReachMD. The following episode was recorded live during a ReachMD Innovation Theater in Chicago, Illinois, where Dr. Matt Birnholz spoke with Dr. David J. Portman, Founder and Director Emeritus of the Columbus Center for Women's Health Research, about hot topics in sexual medicine.

Here's your host Dr. Birnholz.

Dr. Birnholz:
So, Dr. Portman, can you just give us a little bit of background? It's one thing to just state where you come from, how you practice, your affiliations, credentials, but it's another thing to give us an idea of how you got into this practice. You're so prominently involved in clinical research for a number of sexual dysfunction issues. Maybe you can tell us how you got into that field and what work you're doing.

Dr. Portman:
Sure. I think that the essential nature of sexuality, just like eating and the things that we have to do and that we do to sustain ourselves and our species, I realize were so integral to who we are, and yet, in the practice of OB/GYN in particular, and then medicine in general, there really was this gap in knowledge and understanding and experience in sexual health. And I thought that that was such a huge disconnect—that something that everybody does, or most want to do, and yet, there was this conspiracy of silence and a real lack of scientific knowledge in the field. I didn't get much training as an OB/GYN resident or as a medical student, which is really unfortunate, because that's where you first try to get your various interests and then ultimately land in your specialty.

So, when I first went into general OB/GYN practice, I was very interested in clinical research and actually founded a freestanding phase II and III clinical research center, and our bread and butter was contraception and menopause, urogenital atrophy, abnormal bleeding, so just all the things that OB/GYNs do. And when we started to realize that there was this gap in treatments available for women, as opposed to the great progress they made with both PDE5 inhibitors, drugs like Viagra for men and androgen replacement for men, I really felt that that gap needed to be bridged and slowly became involved with the Societies that had an interest. So the International Society for Women's Sexual Health, ISSWSH, which I mentioned and highly recommend that any of you who want a deeper dive into this get involved in, it's a great group of interdisciplinary clinicians. I know somebody asked questions about, "Well, isn't this counseling, psychological issues?" Well, we have lots of sex therapists who belong, psychologists, psychiatrists, as well as urologists and gynecologists.

So I think you have to make the effort, because it's not something that just happens. And when I saw that it was an unmet need, I began to get involved and started doing some of the trials for the various sponsors who recognized that, not only was it an unmet need, but it was a potential nice market opportunity. The more I did that, the more I became engaged with the professional community—the more I read about it and realized that there is a whole literature out there but certainly needed a lot more on the female side.

Dr. Birnholz:
Right. You've touched upon a number of really critical areas. Number one, you talked about this niche that's developing, and it's growing in an interdisciplinary fashion. You mentioned the center that's devoted to this, and it has people from a number of different specialties, number of different practice levels that are all involved in this and actually focusing on sexual disorders, sexual dysfunction. You also talked about the gaps in knowledge, and I want to touch on that real briefly, because in your recent talk about hypoactive sexual desire disorder, you talked about it's clearly an exciting time in clinical research because there's this rapid expansion of knowledge and what we are understanding, but on the flipside of that, there seems to be a problem in that it's a rapidly expanding field with a lot of knowledge

and that the endpoints keep shifting. And you talked about some of the studies that were being done with flibanserin and some others where we're trying to ascertain what were the most clinically useful endpoints. It was vague, it was difficult, and it was changing. So, for our audience here, what in the clinical research can they look at and say, "That's going to be a stable source of information; I can trust that," and what is going to be quickly shifting?

Dr. Portman:
Right. So the official journal for both ISSWSH and the International Society for Sexual Medicine, ISSM, is the Journal of Sexual Medicine. Believe it or not, there's a Journal of Sexual Medicine, and it's fairly balanced between male and female sides, so there's great original research, which is both basic science. Unfortunately, a lot of that is not well-funded here in the States because of—maybe it's our Puritan heritage, and it becomes a political football so that… Do they give grants in this area? It then becomes more of a political issue than an actual scientific issue. But there is a lot of good work, I mentioned, out of Canada where they are looking at the basic physiology of sexual health. There are also lots of clinical trial reports in the Journal of Sexual Medicine as well as reviews, so I think that's a good peer-reviewed source—and then just engaging with your professional societies. But you're right, the sands are shifting, and I think that that's where context and being involved with the ever-evolving landscape really comes in handy.

You mentioned: How does a clinician figure out "whether or not this is clinically meaningful to me"? "I read this paper, and it said that there is this or that." I think one of the things to look at is responder analyses, because that's what we're interested in. "What is a responder like?" "What happens when I have a patient, if she's going to have a good response, what can I tell her?" The problem with all clinical studies is that you're looking at means and not individuals, so when you look at that small difference, say, in an FSFI desire score of only 0.4, that's what the mean is, but it means that there are some women who had a change of 1 or 1.5, which is huge. Right? That takes them to a completely—you know, from never to most of the time thinking or interested in their desire. So that's what we want to know is who is driving the mean in those different directions, which is who do I think may respond, and that's what I certainly am going to advise to continue or take the therapy. And then, who are the non-responders? And I think that's how we practice clinical medicine.

So it's a little challenging when they beat up on the results of this based on a mean, and a good example of that is the number of sexually satisfying events. In the flibanserin study, the FDA's statistician said that—first of all, the sponsor statistician said there was 1 more sexually satisfying event per month compared to placebo on the average, so that means on average. The FDA said there was a half a sexually satisfying event on average, which I'm not quite sure what a half a sexually satisfying event is, but that also shows you how confusing means are. But again, it translated into responders. If you look at responders… And I don't mean to belittle 1 more satisfying sexual event. For a woman who's not having that much satisfaction, that could be huge. If she's only having 1 satisfying sexual event, now she has 2, that's meaningful to her, so who are we to disparage and say that's not significant? So I think even the mean is significant. But then when you look at responders, the number of women who took the treatment versus placebo who had 3 or 4 more satisfying sexual events, was much more likely in women who took the drug versus placebo, so I think that that's really an important thing to look at when you're trying to parse out whether or not this drug is going to achieve any kind of clinically meaningful benefit for your patients.

Dr. Birnholz:
That's fascinating. I want to touch on that, the term of the responder, because that comes back to, perhaps, one of the root cause issues here, which is that in our Puritan society, thou shall not respond because thou shall not talk about sex. You gave us a number of insights in your previous talks about this conspiracy of silence, how we can potentially go about that; but first, how do you see that manifesting even in your own practice with some of your colleagues where it's just difficult to get over this bar of bringing it up or in practices that you visit, and other colleagues who might come to you and say, "I'm not actually sure the best way to bring this up"? "If I just kind of make it some sort of checklist review of systems and try not to even look up because it's just so difficult to bring up, or if I actually do…" As you once said, a 19-part questionnaire that is not going to be very efficient or timely. So, how do you address this conspiracy of silence from a practical perspective?

Dr. Portman:
Well, I think if you look... One of the slides that we presented showed how close—over 80% of the clinicians, and then it goes to primary care doctors, didn't engage or ask about it, and the vast majority, if you look at close to 80%, said it's because they had little or no confidence in discussing it, so I think that's the first hurdle to get over. And personally, that was a challenge for me as well. You're brought up in a culture where some of these things are inappropriate to discuss, even in the confines of the exam room or the consultation room, so you have to overcome some of your own insecurities, and that just takes practice. You have to keep at it. And if it's something that you feel is important, which I think we all do, and instead of punting, embracing it even with your own discomfort, I think that's critical.

I think that the other thing is to normalize and validate it for the patients who are coming into your office and saying, "This is really

common." And ask open-ended questions so that they don't clam up. If you ask yes/no questions, you're not going to get a whole lot of narrative, so I think open-ended questions, normalizing that this is common—"There's a lot of women in your situation who experience this, you don't have to feel bad about it, and I think that there are some things that we can do to help you"—help the patient open up as well. So I think finding out what your own insecurities are and what your own barriers are is critical, being honest with yourself, and then also helping your patients be a little bit more open. But it does take practice, like anything, and you're not going to have a sexual medicine practice overnight, but I think if you make small advances gradually, you'll find that it can be very rewarding for patients because there are things that we can do to help. There was the Hippocrates quote that was on the screen that said, "Cure sometimes, treat often and comfort always," so sometimes just them hearing you is comforting and knowing that this is not abnormal and that it's not all in their head so to say. Although, I showed you a lot of neurobiology, so a lot of it is in their head, but only in the nicest of terms. So those are a few things that I've observed.

Dr. Birnholz:
Right. And I'm sure there are going to be some questions about the neurobiology. There's so much to know there, so much to try to retain. But as far as the concept of comfort from you, I think that there is—and correct me if I'm wrong—I think there is still a lot of confusion around who the "you" is in this. Whose court is sexual medicine in? Primary care, do they punt it off to OB/GYN saying, "That's really in their territory"? Does OB/GYN say, "I should have a sexual therapist on speed dial, and really, it should go out from there"? And then from that side, even within the practice from that universe side, one practice, those members of the team, who's bringing it up there, too? Is it only in the physician's court, or can a PA, the nurses, can it come out there as well? So I think there's just a lot of confusion. Maybe you can address that.

Dr. Portman:
Yes, and I think you're right. And sometimes when there is no quarterback, the team collapses. Right? I mentioned that the DSM is not where we turn to for how do we take care of pretty common conditions, so the fact that it's been in the psychiatry or the sex therapist domain has somewhat limited our ability as clinicians who often have therapeutic modalities to turn to, to really not embrace it. So I think that one, the advances we have in sexual psychopharmacology are huge because it will bring it into the physician's office rather than simply leave it in the therapist's office, but ultimately, it's going to be a very interdisciplinary team that does this, because these are complex problems that did not happen overnight. There are a lot of psychosocial issues that are best handled by a therapist, either a psychologist or a psychiatrist. There may be certain things that are hormonal that your primary care doctor may not be comfortable with. If you start talking about using testosterone, which we don't have any available treatments, "How do I monitor that, and what do I use?" So I think that I would... My preference and probably my prejudice is that I think the OB/GYN is the ideal person to lead this team, but realize that it is a team, that you need... I failed to mention, when you are talking about a significant dyspareunia, even the pelvic floor physical therapist is part of the team, so you want to make sure that you have all of those resources—not necessarily on speed dial to punt but to be able to make sure you can refer in a logical and methodical way. So I think it is going to remain an interdisciplinary specialty, but I think that it's going to take clinicians in each of those areas to pursue proficiency in order for us all to work well together.

Dr. Birnholz:
Makes sense. And as someone who wants to take ownership, say, I want to become the quarterback, for instance, at least from my practice standpoint. I want to really engage in these conversations and develop a team of people that I can bring in from one issue to another.

One question, I think, that is going to come up is—what tools, I think, would make your top 10 list as that quarterback? Because there are so many tools out there. Some of them are more practical than others. What as the quarterback, the person who's going to make that first assessment, who's going to bring it up, going to get past their own insecurities and their own sensitivities—what tools can you bring to that patient encounter to more effectively start managing this patient's sexual issues?

Dr. Portman:
So, there are resources. I mentioned ISSWSH. They do have a lot of information about setting up a sexual health practice. That may involve very simple things like having a screener like the DSDS available for a quick review so that you can, without a huge amount of time, make a pretty validated diagnosis, so I think having some screeners that you're comfortable with, I think having your staff understand that this is something that's important and not to brush off, having it as part of, as you mentioned, review of systems if you're going to ask about, "When was your last Pap smear, and when was your last immunization?" There really should be questions about, "Are you having any sexual difficulties? Do these involve arousal, orgasm, desire? And if so, are you bothered by them?" So those are pretty much right off the DSDS screener.

I think that if you're going to expand a little bit more, I think it's important to understand about what's available in the way of erotica or bibliotherapy to recommend to patients. Sometimes cultural issues and just not being responsive to sexual cues can respond to some very modest behavioral changes by giving the patient permission. There's a model for this called PLISSIT, which kind of can gradually

ease into just from permission, permission for the patient and you to talk about it, to limited information—"Well, here is what you can try; maybe you should try to read some erotica to get connected to that part of yourself that you feel you have lost;"—to teach them, give them limited information, and then specific suggestions that may get you a little bit closer to where the sex therapist is going to get involved, and using certain techniques. You need to be comfortable recommending masturbation and toys and lubricants. These are all things that we take for granted, that everybody knows about these things, and depending on culture and comfort, there are some that are not comfortable with that, so that's part of that permission-giving. That takes time to broach those subjects in a way that is not alarming to the patient, that they feel that that's a very helpful recommendation. If you have somebody who has an arousal disorder, focused masturbation and other things can certainly help in that regard; although, there may again be a need for pharmacotherapy intervention. So those are the kind of things that we think about when we're talking about a sexual medicine practice—and then all the other adjunct players, having a good pelvic floor physical therapist to refer to for people who have vaginismus or penetrative disorders or pain disorders, pelvic floor problems, pelvic floor hypertonicity leading to pain, and then having a good certified sex therapist available as part of the team as well, a urologist who might be able to assist with the male partner, because sometimes it's often a couple's problem. If you have a woman with moderate GSM and her husband with moderate ED, that is a recipe for failure. A highly functional partner and a moderately affected partner may be able to get by, but if you have both who need treatment, then it's important to take that as an interdisciplinary, as a couple's problem. And I think that couple factor is welcome the partner into the conversation. By partner, I mean male or female. I think you have to be open and acknowledge that not everybody is having heterosexual, normative, vanilla sex. You have to be willing to talk about some of the alternative lifestyles or just simple differences in preference. Again, it's a matter of comfort. It takes a great deal of time to do that. You're not going to start out right off the bat talking about dildos and vibrators the first time you have a conversation about sexual health, but eventually, you will get comfortable, because it's natural, and if you can make the patient comfortable, then they'll welcome the suggestion.

Dr. Birnholz:
Have you found any differences in follow-up compliance rates in bringing in partners? Does that help improve the follow-up? Because if it's uncomfortable for patients to bring up and it's uncomfortable for physicians and other healthcare practitioners to bring up not just once but the next time around, does bringing in a partner help with that?

Dr. Portman:
Yes, it does. And, unfortunately, I think this is also part of our paternalistic culture, is that often you'll see a male partner having told… And I think that somebody alluded to this earlier. Isn't this just the husband asking for the woman to be put on a medication? Fix her, right? I want to have sex 5 times a week. She only wants to have sex 2 times a week. But she has no dysfunction, right? That's just a discordance, so that's a pretty easy fix. You have to come up with some compromising activities and schedule for them. That's not a sexual dysfunction. That's a sexual discordance, and that's very common. Talking to partners about that, saying, "It's not abnormal for 1 partner to have greater drive than the other, so you need to figure out how you meet in the middle," and having that conversation can really resonate with the partner, who then isn't going to continue to throw it into the other person's field. It's actually the couple that needs to be addressed.

Dr. Birnholz:
Well Dr. Portman, Before I let you go, anything that we didn't ask you collectively that you wanted to either reiterate or just impart to our audience?

Dr. Portman:
No, I just think that this is a great format. And hopefully, if this has not convinced you to make this part of your practice, at least be open to helping your patients find the help that they do need.

Dr. Birnholz:
It's a perfect parting comment. I want to thank Dr. David Portman for joining us, and we'll see you soon.

Dr. Portman:
Thank you.

Announcer:
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